NEW PATIENT REGISTRATION

NORTH TEXAS HEART CENTER
Baylor Medical Plaza – Wadley Tower
3600 Gaston Avenue, Suite 851
Dallas, TX 75246

Last Name: _____ First: _____ Middle: _____

SSN: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Male: ____ Female:____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email: _____

Referring Doctor: _____ Phone #: _____ City: _____

Primary Care Doctor: _____ Phone #: _____

Medical reason why you are here today: _____

Have you ever been to this Office before: Yes____ ,When_____ No____

Have you ever seen a Cardiologist before? If Yes, Name, Phone # & City: _____

_____

Please List All Medical Problems including any prior Surgeries:

Type of Problem/Illness/Surgery/Hospitalization:	Date:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____

(for additional space, please use reverse side of this form)

Please List ALL your Medications including Vitamins and Supplements:

Name of Medication:	Dose/Strength:	Times Taken Daily:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____

(for additional space, please use reverse side of this form)

ALLERGIES to medicines or other substances: Yes: ____ , If Yes, list No: _____

1._____ 3. _____

2. _____ 4. _____

(for additional space, please use reverse of this form)

Circle "Y" for YES and "N" for NO:

1. Do you use tobacco? Y N How much _____ # of Years _____
2. Do you drink alcohol? Y N How much _____ # of Years _____
3. Do you have high Cholesterol? Y N Last time checked _____
4. Do you have high Blood Pressure? Y N # of Years _____
5. Do you have Diabetes? Y N # of Years? _____
6. Do you exercise regularly? Y N How Often? _____
7. Your current Weight? _____ Weight 1 year ago _____ Weight 5 years go_____
8. Are you married? Y N # of Years _____
9. Do you Eat Healthy? Y N 10.What do you do for Fun? _____
10. Highest Level of Education? _____

Family Member	*Current Age*	*Health Problems*	*Age & Cause of Death*
Father			
Mother			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			

Have you had any of these following symptoms in the past 6 months?
(circle "Y" for YES, circle "N" for NO)

Excessive fatigue	Y	N	Pain in joints	Y	N
Generalized weakness	Y	N	Leg pain on walking	Y	N
Intolerance to cold or heat	Y	N	Leg pain at night	Y	N
Loss of appetite	Y	N			
Fever	Y	N	Anxiety	Y	N
Chills	Y	N	Depression	Y	N
Night sweats	Y	N	Mood swings	Y	N
Easy bleeding or bruising	Y	N	Memory difficulties	Y	N
Cough	Y	N	Weakness in arms or hands	Y	N
Wheezing or Asthma	Y	N	Weakness in Legs or Feet	Y	N
Bronchitis	Y	N	Balance or Falling problems	Y	N
Coughing up blood	Y	N	Seizures	Y	N
			Slurred speech	Y	N
Pressure in chest	Y	N	Unusual headaches	Y	N
Tightness in chest	Y	N	Blurry or double vision	Y	N
Heaviness in chest	Y	N			
Chest Pain on walking	Y	N	Frequent indigestion	Y	N
Chest Pain without walking	Y	N	Acid reflux	Y	N
			Abdominal pains	Y	N
Shortness of breath	Y	N	Nausea and Vomiting	Y	N
Breathless while walking	Y	N	Blood in Stool	Y	N
Breathless lying flat	Y	N			
Swelling of feet or legs	Y	N	Frequent urination	Y	N
Lightheaded or Dizziness	Y	N	Painful urination	Y	N
Palpitations/fast heart beat	Y	N	Urine Infection	Y	N
Fainting spells	Y	N	Erectile dysfunction (men)	Y	N